STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

DANNEL P. MALLOY
GOVERNOR

MIRIAM DELPHIN-RITTMON, PH.D.
COMMISSIONER

Testimony by Miriam Delphin-Rittmon
Commissioner
Department of Mental Health and Addiction Services
Before the Judiciary Committee

Good morning, Senator Coleman, Representative Tong, and distinguished members of the Judiciary Committee. I am Miriam Delphin-Rittmon, Commissioner of the Department of Mental Health and Addiction Services (DMHAS), and I am here today to comment on HB 5531 AN ACT CONCERNING THE CARE AND TREATMENT OF PERSONS WITH A MENTAL ILLNESS OR SUBSTANCE USE DISORDER. While our Department respects the role the Judiciary Committee has in ensuring public safety we have serious concerns regarding the content of this bill.

This bill describes practices that are components of what is commonly referred to as outpatient commitment. The people we serve, and those in our advocacy community, refer to these practices as "forced medication" and as practices that do not respect individual choice regarding medical and behavioral healthcare. Over the past 15 years the DMHAS' behavioral health system of care has evolved into an approach that is person-centered and recovery-oriented. The evolution has helped us understand that the relationship between the caregiver and the individual is a collaborative one founded on mutual and thoughtful respect. Our experience and DMHAS clients have informed us that treatment planning, coordination of care, and discharge planning are most effective if developed with the individual served taking the lead in the architecture of the plans. Ultimately, tailoring a treatment plan to a person's stated needs will be more successful; this plan may or may not include medication.

Alarmingly, this bill encompasses both individuals with "a diagnosed mental illness or substance use disorder" who are *capable of giving informed consent*. The tenets of outpatient commitment take a significant departure from those of the recovery movement and remove the desirable possibility of an individual's full participation in decisions regarding medication administration. It is paternalistic and as presented in this bill would not be able to be operationalized in the community (e.g. oral medication may be prescribed two or three times daily). Intervention to which a person does not consent creates distrust between the treatment system and those it is built to serve. We see our role as one of engagement not estrangement, even when individual needs are complex.

A medical analogy may illuminate some of our thinking. Chronic high blood pressure, high cholesterol or diabetes, for example, may be potentially life-threatening. For a variety of reasons, patients may not follow doctor's orders, including a diet or medication regimen, for these or other illnesses. Patients seeking medical care are not forcibly medicated even if they are transported to emergency departments with uncontrolled glucose levels or cardiac symptoms. Instead, the medical community looks to provide

incentives to help people develop, embrace and reach their goals. Outpatient commitment for the behavioral health client is contrary to these practices.

I would also like to emphasize the high costs associated with implementation of this bill. Resource-intensive mechanisms at both the state and community level would be required to implement the strategies outlined in this bill. Per this bill, resources would be required for: probate court, conservators, ambulance transportation, law enforcement support, emergency department care including medical personal to implement forcible medication administration, and potentially, paraprofessional, or medical staff to restrain individuals who are not consenting to medication administration.

Connecticut has many programs that are nationally acclaimed. Some examples include: Community Intervention Teams (CIT) who partner with local police departments to de-escalate problems in the community; Supportive Housing Programs that offer safe and affordable housing and care management to help persons with serious mental illness remain housed and responsible neighbors. DMHAS system of care includes community support services, medication management and peer supports. All of the services I referenced emphasize an individual's choice, the right to live in the community and to enjoy the privileges of citizenship. None of these programs involve force. They are effective. All of these programs engage the people we serve and honor their choices while assuring their safety as well as the public's safety.

An outpatient commitment statute would disrupt the collaborative relationship between caregivers and individuals and take human and fiscal resources away from recovery-oriented treatment. It would not enhance clinical care, community safety or support recovery. We ask that you not act favorably on the legislation before you.

I thank you for your time and attention to these matters and would be happy to answer any questions you may have.